

The Economics of Life and Death: Morals and Ethics in an Environment of Medical-Resource Scarcity

B R A N D O N T R A S K *

I. INTRODUCTION

Decisions relating to the withholding or withdrawing of life-sustaining treatment are fraught with medical, moral, ethical, and legal issues.¹ These determinations are often made in emotionally charged environments.² The question of whether life-sustaining treatment should be provided in any particular case is very difficult to address. This is particularly true in cases where the patient is not in a position to make his wishes clear to the attending physicians, leaving doctors and family members to consider what should be done with very little – if any – guidance other than their own values, morals, ethics, beliefs, and desires.³

Although recommendations by doctors to withhold or withdraw life-sustaining treatment are accepted by family members in approximately 98 percent of cases,⁴ the remaining cases are often quite contentious, and are appearing in the court system with increasing frequency.⁵ Concerns about medical-resource scarcity often feature prominently in cases where there is

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¹ Sam Solomon, “End-of-life war outlives Golubchuk” *National Review of Medicine* (July 2008), online: *National Review of Medicine* <http://www.nationalreviewofmedicine.com/issue/2008/07/5_patients_practice_07.html>.

² David Orentlicher, *Matters of Life and Death: Making Moral Theory Work in Medical Ethics and the Law* (Princeton, NJ: Princeton University Press, 2001) at 140.

³ Pat Murphy, George C Webster & Brian Chaze, “The Problem With Home Remedies: Manitoba, Doctors and Unilateral Decisions in End-of-Life Care” (2010) 10:3 *American Journal of Bioethics* 71 at 72.

⁴ Orentlicher, *supra* note 2.

⁵ Solomon, *supra* note 1.

disagreement between physicians and family members about whether life-sustaining treatment should be provided, though this issue is rarely framed as one involving cost considerations.⁶ Courts have a great deal of difficulty dealing with these cases in an effective and efficient manner; quite often, the individuals at the focus of the litigation perish before final rulings are made.⁷ Additionally, it is difficult to glean a clear interpretation of the law through a review of the relevant rulings to date.⁸

In 2008, in response to the issues arising from the much-publicized case of Samuel Golubchuk,⁹ the College of Physicians and Surgeons of Manitoba (“the CPSM”) released a statement outlining its position on withholding or withdrawing life-sustaining treatment.¹⁰ Importantly, the statement purports to give doctors the ability to make a unilateral decision to withhold or withdraw life-sustaining treatment in cases where there is disagreement between physicians and family members as to whether this treatment should be provided.¹¹ It must be noted that, because this is a statement rather than a guideline, it constitutes “a formal position of the [CPSM] that requires compliance.”¹² Any physician that fails to abide by the CPSM statement opens themselves to the possibility of disciplinary action.¹³

This paper will examine whether Canadian doctors should have the ability to make unilateral rationing decisions in situations involving the possibility of ongoing life-sustaining treatment. It is important to note that

⁶ Orentlicher, *supra* note 2.

⁷ Solomon, *supra* note 1.

⁸ Jocelyn Downie & Karen McEwen, “The Manitoba College of Physicians and Surgeons Position Statement on Withholding and Withdrawal of Life-Sustaining Treatment (2008): Three Problems and a Solution” (2009) 17 Health L J 115 at 116.

⁹ “End-of-life report fails: Golubchuk family” CBC News (28 March 2011), online: CBC News <<http://www.cbc.ca/news/canada/manitoba/story/2011/03/28/mb-report-whitewash-golubchuk-manitoba.html>>.

¹⁰ College of Physicians & Surgeons of Manitoba, Position Statement, 1602, “Withholding and Withdrawing Life-Sustaining Treatment” (30 January 2008), online: CPSM <<http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/st1602.pdf>>.

¹¹ *Ibid* at 11. However, it is interesting to note that the CPSM acknowledges that its statement “cannot impose legal obligations or create legal rights in respect to physicians.” This raises interesting questions, outside the scope of this paper, about requiring physicians to perform certain actions in order to satisfy their professional and ethical duties that may contradict their legal obligations.

¹² Joel B Zivot, “The Case of Samuel Golubchuk” (2010) 10:3 American Journal of Bioethics 56 at 56.

¹³ *Ibid*.

the discussion is specific to the Canadian context, as the Canadian healthcare system is primarily public in nature. Additionally, it is focused on cases involving decisions of treatment withdrawal (that is, after life-sustaining treatment has initially begun) rather than the withholding of initial treatment.¹⁴ Further, this analysis is limited to cases involving a legally incompetent patient where there is no advance directive in place and where family members disagree with the physician's recommendation to withdraw life-sustaining treatment.¹⁵ Particular emphasis will be placed on the subject of medical-resource scarcity and the conflation of cost-benefit analyses with the concept of medical futility.¹⁶ Finally, the beginnings of an alternative approach based on principles of administrative law—with the aim of minimizing litigation—will be discussed as a potential way to deal with cases where there is disagreement between physicians and families relating to the provision of life-sustaining treatment.¹⁷

II. MEDICAL-RESOURCE SCARCITY AND MODELS FOR ALLOCATION

A. Medical-Resource Scarcity

First, it is important to acknowledge that every healthcare system in the world has a perpetual shortage of medical resources.¹⁸ This means that not every individual can be cared for, and that not every medical condition can be

¹⁴ This limitation is necessary as there are different moral and ethical considerations involved with treatment withdrawal than there are with the withholding of life-sustaining treatment in the first place. See: Franklin G Miller & Robert D Truog, *Death, Dying, and Organ Transplantation: Reconstructing Medical Ethics at the End of Life* (New York: Oxford University Press, 2012).

¹⁵ This limitation is necessary as there are mechanisms in place to deal with other types of cases. This paper is focused on very specific circumstances.

¹⁶ This paper adopts a narrow and objective interpretation of the concept of medical futility. Essentially, in order to be considered “medically futile,” a course of treatment would offer no medical or physiological benefit whatsoever. See discussion at 242-246, below. See also Orentlicher, *supra* note 2.

¹⁷ This paper approaches a potential administrative tribunal in very general terms. The primary goal of this paper is to investigate the issues surrounding bedside-rationing decisions and not to create a blueprint for the establishment of an administrative tribunal. A separate study would be required prior to the implementation of any such body.

¹⁸ Alan Jorkowitz, Shimon Glick & Ari Z Zivotofsky, “The Case of Samuel Golubchuk and the Right to Live” (2010) 10:3 *American Journal of Bioethics* 50 at 52.

treated. There will never be enough doctors, nurses, beds, machines, drugs, or organs to take care of everyone in need. This is true of all medical systems, regardless of either their stated objectives, or how they are designed.¹⁹

Demand for medical resources will always exceed supply. Given the continual shortage of medical resources, each society needs some sort of mechanism for determining who will have access to treatment and who will not. There are a number of systems in place across the globe, and no two countries' systems are exactly similar. In general, though, it seems that societies have failed to adequately address issues of resource allocation. This has resulted in doctors, by necessity, assuming the role of decision-maker, despite having very little guidance as to how to approach such decisions. The next part of this paper will analyze these issues within the two systems most familiar to the average Canadian: the private system (in place in the United States), and the socialized system (in Canada, this takes the form of a single-payer system).

1. Private Systems

The American-style, market-economy approach to healthcare delivery is based on the notion that people's values are best reflected by what they are prepared to pay for a good or service on offer in a competitive market.²⁰ The theory is that people will spend their dollars on the goods and services they want at precisely the values they affix to those goods and services.²¹

The American system is dominated by a handful of insurance companies and "health maintenance organizations"²² ("HMOs") which offer consumers—that is, future patients—the ability to purchase a variety of coverage packages, based (in theory) on their wants and anticipated needs.²³ Insurers and HMOs are responsible for determining which treatments are approved for coverage and which are not. Costs of insurance packages are determined through actuarial estimates, taking into account a number of different factors,

¹⁹ *Ibid.*

²⁰ Samuel Bowles, Richard Edwards & Frank Roosevelt, *Understanding Capitalism: Competition, Command, and Change*, 3d ed (New York: Oxford University Press, 2005) at 197.

²¹ *Ibid.*

²² Steffie Woolhandler & David U Himmelstein, "The High Costs of For-Profit Care" (2004) 170:12 *Canadian Medical Association Journal* 1814.

²³ *Ibid.*

including occupation, age, weight, height, existing medical conditions, and family health history.²⁴

Conservative economists would argue that the private healthcare system is quite clear and efficient, as those who value a certain treatment more than others will receive that treatment over the others.²⁵ Those who are not prepared to pay what the market demands do not receive that particular treatment (unless it is offered through a co-existing public system) unless supply increases or demand decreases. This model is very good for doctors, as physician salaries in the US are amongst the highest in the world.²⁶ There is also the very real potential for savvy investors to make a lot of money through insurance companies and HMOs.²⁷ Also, it can be argued that competition through the market system leads to first-rate service in the US, as doctors, clinics, and hospitals will compete for consumers' (patients') dollars by trying to outdo each other.

However, this argument overlooks some very basic points. First, it should be noted that healthcare is a unique service.²⁸ How exactly should a person go about determining how much he values an additional two weeks of life? Though impossible to gauge, it is likely that everyone places a similarly high value on the ability to continue living.²⁹ Without life itself, values in life—including those demonstrated in a market economy—hardly matter. In the absence of an ability to continue living, funds cannot easily be directed toward the acquisition of another good or service. A continued existence is a necessary prerequisite to the taking of any action in the market economy.³⁰

Secondly, there is the (surprisingly) oft-ignored problem of inequality. Someone may value an extra two weeks of life very highly but be unable to express this value in the marketplace due to a lack of funds in comparison to others competing for the scarce medical resources necessary to extend life. This problem is best described by economists Samuel Bowles, Richard Edwards, and Frank Roosevelt:

²⁴ *Ibid.*

²⁵ Bowles, Edwards & Roosevelt, *supra* note 19.

²⁶ Woolhandler & Himmelstein, *supra* note 21.

²⁷ *Ibid.*

²⁸ *Ibid.*

²⁹ Govind Persad, Alan Wertheimer & Ezekiel J Emanuel, "Principles for allocation of scarce medical interventions" (2009) 373 *Lancet* 423.

³⁰ Bowles, Edwards & Roosevelt, *supra* note 19.

It is sometimes said that markets are like elections, in which consumers “vote” with their dollars for the commodities they want. If a large number of dollar “votes” are cast for yellow shirts, a large number of yellow shirts will be produced. In a capitalist economy, competition for profits will see to it that resources are allocated in such a way as to produce commodities in the proportions determined by dollar votes.

Voting for commodities in markets is an unusual kind of election, however, because some people vote more times than others. If every dollar of household income had been cast as a vote in 2002, the average household in the richest fifth of the US population would have had more than 14 times as many votes (143,559) as the average household in the poorest fifth (9,931). Rather than the one-person, one-vote principle of democracy, this is more like an economic version of ballot-box stuffing.³¹

2. *Socialized Systems*

In Canada, the public nature of the healthcare system³² raises a number of interesting additional questions with respect to how society should deal with the ineluctable state of medical-resource scarcity. While not every treatment type requires or consumes the same kind of medical resources (for instance, cancer treatment demands different specialists, equipment, and medication than treatment for a heart condition), it is true that every dollar spent on one type of care for one patient is one fewer dollar available to be spent on a different type of care for another patient.³³

It can be convincingly argued that governments should put greater funding toward cure-or prevention-focused healthcare rather than care-focused healthcare, for the obvious reason that cure- or prevention-focused spending has the potential to aid a larger number of people in the long run.³⁴

³¹ *Ibid* at 222.

³² For more information about Canada’s healthcare system, see: “Indepth: Health Care” CBC News (22 August 2006), online: CBC News <<http://www.cbc.ca/news/background/healthcare/>>.

³³ Arthur S Berger, *Dying & Death in Law & Medicine: A Forensic Primer for Health and Legal Professionals* (Westport, CT: Praeger Publishers, 1993) at 59.

³⁴ See generally JF Fries et al, “Reducing Health Care Costs by Reducing the Need and Demand for Medical Services” (1993) 329:5 New Eng J Med 321; JF Fries et al, “Beyond Health Promotion: Reducing Need and Demand for Medical Care” (1998) 17:2 Health Affairs 70; Julio SG Montaner et al, “The Case for Expanding Access to Highly Active Antiretroviral Therapy to Curb the Growth of the HIV Epidemic” (2006) 368 Lancet 531; Aranka Anema, Evan Wood & Julio SG Montaner, “The Use of Highly Active Retroviral Therapy to Reduce HIV Incidence at the Population Level” (2008) 179:1 Canadian Medical Association Journal 13; John RC Wheeler et al, “Can A Disease Self-Management Program Reduce Health Care Costs? The Case of Older Women with Heart Disease”

After all, in Canada, the “aim is to use the resources available to provide beneficial...treatment to those who need it, regardless of income or other irrelevant factors.”³⁵ Although healthcare dollars are disproportionately spent on end-of-life care at present, governments are becoming increasingly hesitant to dedicate medical resources to life-sustaining treatment in cases in which it is clear that there is little hope of significant recovery.³⁶

Recent cases demonstrate that the matter of how to deal with decisions relating to ongoing care within a public healthcare system is a highly controversial issue.³⁷ Who should be able to put an end to treatment? More specifically, should doctors have the right to refuse further treatment against the wishes of family members?

In answering these questions, it is important to bear in mind the unique structure of Canada’s healthcare system, which stands in stark contrast to the primarily privatized healthcare system of the US. In a privatized system, individuals and their families are, at least in theory, able to devote as much money as they want (or can afford) to any medical procedure, as medical resources – at least for the most part – are allocated through a traditional capitalist supply-and-demand model.

In many ways, a private healthcare system offers – or at least purports to offer – very simple solutions to all of these moral and ethical issues. It simply bypasses these concerns. If someone cannot afford to pay for treatment, then he or she does not receive treatment. Doctors and politicians are theoretically able to wipe their hands clean of the issues surrounding treatment decisions and resource allocation;³⁸ after all, the blame for a person’s death falls squarely on market forces (Social Darwinism – the notion of survival of the fittest in a free-market economy – is alive and well in the US)³⁹ and not on

(2003) 41:6 Medical Care 706.

³⁵ Tracey M Bailey & Brendan Leier, “The Case of Samuel Golubchuk and the Right to be Spared an Excruciating Death” (2010) 10:3 American Journal of Bioethics 67.

³⁶ Orentlicher, *supra* note 2 at 139.

³⁷ Solomon, *supra* note 1.

³⁸ Much debate exists as to the effectiveness of such a system. For general discussion on how private financing can negatively affect access and equality see Francesca Colombo & Nicole Tapay, *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems* (OECD Health Working Papers No 15) (Paris: OECD, 2004) 7; Carolyn Hughes Tuohy, Colleen M Flood & Mark Stabile, “How Does Private Finance Affect Public Health Care Systems?: Marshalling the Evidence from OECD Nations” (2004) 29:3 J Health Pol 359.

³⁹ Rodolfo Leyva, “No Child Left Behind: A Neoliberal Repackaging of Social Darwinism”

decisions made by healthcare providers or officials. A wholly public system complicates this, as (at least in theory) one's financial means should have no influence on the type or amount of care received.⁴⁰ Therefore, still recognizing the existence of scarcity, the public system requires further methods of allocation.

B. Models for Allocation

Bioethicists Govind Persad, Alan Wertheimer, and Ezekiel J Emanuel detail eight allocation methods, which "can be classified into four categories, according to their core ethical values: treating people equally, favouring the worst-off, maximising total benefits, and promoting and rewarding social usefulness."⁴¹ This section will outline those eight methods by category, and weigh the benefits and drawbacks of each. It is important to note that most healthcare systems in the world employ some combination of these methods in the allocation and delivery of treatment.⁴²

(2009) 7:1 *Journal for Critical Education Policy Studies* 365.

⁴⁰ There can, however, be 'means-testing' within a public system. See for e.g. the introduction of income consideration in determining rebate amounts in Australia: Australian Government: Australian Taxation Office, "Changes to Private Health Insurance and Medicare Levy Surcharge" (2012), online: Australian Government <<http://www.ato.gov.au/Individuals/Medicare-levy/In-detail/Medicare-levy-surcharge/Changes-to-private-health-insurance-rebate-and-Medicare-levy-surcharge/>>; see also the debate regarding P3 (public-private-partnership) hospitals in Ontario: Adam Radwanski, "Ontario Liberals mull means testing for provincial benefit programs", *The Globe and Mail* (7 March 2013) online: *The Globe and Mail* <<http://www.theglobeandmail.com/news/politics/ontario-liberals-mull-means-testing-for-provincial-benefit-programs/article9396879/>>. For further discussion on the pros and cons of a means-tested system, see Jonathan Gray, "Home Care in Ontario: The Case for Copayments" (2000) 8 *Health LJ* 177; Richard L Kaplan, "Means-Testing Medicare: Retiree Pain for Little Government Gain" (2006) 9:3 *J Retirement Plan* 22; Mary Ruggie, *Realignments in the Welfare State: Health Policy in the United States, Britain, and Canada* (New York: Columbia University Press, 1996); Mary Ruggie, "Learning from Other Countries: Comparing Experiences and Drawing Lessons for the United States" in Bernice A Pescosolido et al, eds, *Handbook of the Sociology of Health, Illness, and Healing* (New York: Springer, 2011) 85.

⁴¹ Persad, Wertheimer & Emanuel, *supra* note 28.

⁴² *Ibid.*

3. Treating People Equally

With a view to treating people equally, Persad et al outline two possible allocation methods: allocation by lottery, or first-come, first-served allocation.⁴³ Allocation by lottery is used in a number of contexts across the globe, most often with respect to education and immigration matters and the distribution of vaccines.⁴⁴ There are a number of advantages to a lottery approach, including simplicity, incorruptibility (at least in theory), and equal opportunity, as decisions are left to the “luck of the draw.” Unfortunately, this approach may also be viewed as being blind to otherwise relevant considerations, such as an evaluation of potential advantages and opportunity-cost analyses.⁴⁵

First-come, first-served allocation, on the other hand, allows doctors to refrain from the discontinuation of medical treatment, even in cases where other criteria may lead to treatment withdrawal in order to shift allocation to new patients.⁴⁶ However, in reality, this system hardly treats individuals equally, as it “favours people who are well-off, who become informed, and travel more quickly, and can queue for interventions without competing for employment or child-care concerns.”⁴⁷

4. Favouring the Worst-Off

In contrast with the view to treating people equally is a view referred to as “prioritarianism”, under which the aim is to favour the worst-off.⁴⁸ As with allocation, this view also breaks into two possible approaches. One approach used in many systems purports to treat the sickest individuals first, meaning that those with conditions that, if left untreated, would have the worst future prospects are moved to the front of the line. This is a very popular approach, and is widely viewed as being “intuitively obvious”⁴⁹—society should save those who are dying, but are still savable with treatment. However, this view overlooks the progressive nature of many conditions; that is, as others who are initially healthier wait for sicker individuals to receive treatment first, their conditions deteriorate to the point that later treatment may not be sufficient

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ *Ibid* at 423-24.

⁴⁶ *Ibid* at 424.

⁴⁷ *Ibid.*

⁴⁸ *Ibid* at 424-25.

⁴⁹ *Ibid* at 424.

to return them to full health. Additionally, as Persad, Wertheimer, and Emanuel state, “when interventions are persistently scarce, saving the progressively ill person later will always involve depriving others.”⁵⁰ Because of this, they rightly conclude, “[W]hen we cannot save everyone, saving the sickest first is inherently flawed.”⁵¹

Another system of prioritarianism allocates scarce medical resources on the basis of age, prioritizing the young over the old. The basis for this approach – which is often taken in the allocation of transplant organs and dialysis machines—is the belief that society should help those who are the worst-off in the sense that they “would otherwise die having had the fewest life-years.”⁵² It is quite true that the allocation of healthcare resources to the young is typically very efficient,⁵³ and would “[enhance] one’s chances of longer, better survival at a later stage of life.”⁵⁴ This approach ignores prognoses, though, and may quite correctly be viewed as unconditionally ageist.⁵⁵

5. *Maximizing Total Benefits*

With the utilitarian (in the general sense of the word) view of maximizing benefits, there are a further two possible approaches to resource allocation.⁵⁶ The first focuses on saving the greatest number of lives possible. All medical systems take this approach, at least to some degree.⁵⁷ This system’s greatest strength is also its greatest weakness—it values all lives similarly.⁵⁸ Although

⁵⁰ *Ibid* at 425.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ Margaret P Battin, “Global Life Expectations and the Duty to Die” in James M Humber & Robert F Almeder, eds, *Is There a Duty to Die?* (Totowa, NJ: Humana Press, 2000) 3 at 6.

⁵⁴ *Ibid.*

⁵⁵ Persad, Wertheimer & Emanuel, *supra* note 28 at 425. While it may be argued that prioritization in this manner is discriminatory, that argument is countered by the idea that, because everyone ages, it is not inequitable to deprive the older of what they have already had, while it would be inequitable to deprive the young of the same. See e.g. Alan Williams, “Inequalities in Health and Intergenerational Equity” (1999) 2:1 *Ethical Theory and Moral Practice* 47.

⁵⁶ Persad, Wertheimer & Emanuel, *supra* note 28 at 425.

⁵⁷ Orentlicher, *supra* note 2 at 139.

⁵⁸ Persad, Wertheimer & Emanuel, *supra* note 28 at 425.

this avoids the comparison of individual lives, it also ignores the different potential benefits of treatment to different people.⁵⁹

The second approach to maximizing benefits emphasizes the importance of saving as many “life-years”⁶⁰ as possible. This places a great deal of emphasis on prognoses. It has intuitive appeal, as many people value a long life very highly.⁶¹ However, the main shortcoming of this approach is that it values quantity over quality; there is no true consideration of quality of life.⁶² This presumes that everyone (or at least the vast majority of people in society) values the continuation of life above quality of life. However, as Stuart F Spicker, professor of community medicine and healthcare at the University of Connecticut, states, “[B]eing alive, mere survival, is not always the highest value or preference voiced by a patient.”⁶³ He believes that “quality of life considerations also must be weighed...in making what is frequently a choice based on what it means...to have a life, and not just remain alive.”⁶⁴ It is also important to note that people often change their views about quality of life as they age.⁶⁵

6. Promoting and Rewarding Social Usefulness

The final category of approaches presented by Presad et al promotes and rewards social usefulness of treatment.⁶⁶ This is arguably the most problematic category, as it is extremely value-laden. Instrumental-value allocation gives priority to individuals on the basis of enabling or encouraging “future usefulness.”⁶⁷ For instance, healthcare workers would be given preferential treatment because, once they recover as a result of treatment, they can then treat others, helping a large number of people.⁶⁸ Responsibility-based allocation — where individuals are given healthcare after agreeing to quit

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² *Ibid.*

⁶³ Stuart F Spicker, “ICU Triage: the ethics of scarcity, the ideal of impartiality and the inadvertent endorsement of evil” in Robert Lee & Derek Morgan, eds, *Death Rites: Law and ethics at the end of life* (New York: Routledge, 1994) 91 at 93.

⁶⁴ *Ibid.*

⁶⁵ Manitoba Law Reform Commission, Report, 109, “Withholding or Withdrawing Life Sustaining Medical Treatment” (December 2003) at 69.

⁶⁶ Persad, Wertheimer & Emanuel, *supra* note 28 at 425.

⁶⁷ *Ibid* at 426.

⁶⁸ *Ibid.*

smoking or to eat more healthily, with an aim of minimizing resource consumption in the long run — also falls under the practice of instrumental-value allocation.⁶⁹

The other usefulness approach is reciprocity allocation, which rewards past usefulness to society.⁷⁰ Again, this is extremely value-laden, and an emphasis on past accomplishments is blind to future contributions and potential outcomes.

As previously mentioned, no healthcare system in the world uses just one of the above approaches; different combinations are used in different places. Nonetheless, it is important to have a basic understanding of the principles and considerations informing allocation decisions in public healthcare systems.

The most significant problem with all approaches to medical-resource allocation lies with the fact that every decision to prioritize care — determining who will receive treatment and who will not — is an expression of values. Who decides which values are the most important? How should the values of incompetent individuals be determined in a societal context? Whose values should win out where there is conflict, bearing in mind that there will always be conflict where there is perpetual scarcity?

III. MEDICAL-RESOURCE RATIONING — NOT AN EXERCISE IN FUTILITY

It is vital to appreciate the differences between a medical opinion and an ethical evaluation. In their description of the various resource-allocation methods, Persad, Wertheimer, and Emanuel argue that it is often “wrongly [suggested] that allocation can be based purely on scientific or clinical facts, often using the term ‘medical need.’”⁷¹ It is important to recognize that, although it may be reassuring to think that rationing decisions are made in a purely objective medical context, in reality “[t]here are no value-free medical criteria for allocation.”⁷²

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*

⁷¹ *Ibid.* at 423.

⁷² *Ibid.*

Cost considerations are often couched in discussions about medical effectiveness or futility.⁷³ Whilst donning lab coats and stethoscopes, doctors will often subconsciously perform cost-benefit analyses before making recommendations in any particular case.⁷⁴ In fact, a survey of doctors in four European countries showed that 56.3% of respondents reported that they had engaged in the rationing of interventions in the six months prior to the study.⁷⁵ Members of the public are led to believe that these recommendations are made solely on the basis of medical-science concerns, though, in actuality, social-science considerations play a large role in the formulation of proposals.⁷⁶

While it is true that “the medical and the ethical are intimately entwined”⁷⁷ and that “physicians are regularly asked to make decisions that blur these boundaries,”⁷⁸ doctors should not be permitted to mislead others – intentionally or unintentionally – through the use of imprecise and improper terminology in explaining their recommended course of action in any particular case. Purely ethical judgments should not be described as medical decisions. As David Orentlicher, professor of both law and medicine at Indiana University, states:

By calling a treatment medically futile, a physician is suggesting that we have a situation in which treatment provides no medical benefit. In other words, even if the treatment were inexpensive, or we had much greater resources to pay for health care, we would not want physicians to offer the treatment to patients... Futile treatments should not be given to patients because physicians should administer treatments only when they provide a real benefit... Physicians must practice in accordance with medicine’s fundamental goal of reversing or halting the deterioration of patient health.⁷⁹

Futility is a concept often misunderstood by both the public and the medical profession. Quite simply, as Orentlicher articulates, “Futile treatments are treatments that do not work.”⁸⁰ A conclusion that a particular

⁷³ Orentlicher, *supra* note 2 at 132.

⁷⁴ *Ibid* at 139.

⁷⁵ Samia A Hurst et al, “Prevalence and Determinants of Physician Bedside Rationing: Data from Europe” (2006) 21:11 *Journal of General Internal Medicine* 1138 at 1140.

⁷⁶ Orentlicher, *supra* note 2 at 132.

⁷⁷ Christopher A Riddle, “The Right to Live: Priority and the Roles of Physicians” (2010) 10:3 *American Journal of Bioethics* 69 at 70.

⁷⁸ *Ibid*.

⁷⁹ Orentlicher, *supra* note 2 at 132.

⁸⁰ *Ibid* at 133.

treatment would be futile can be reached only where a complete “lack of benefit has been ascertained by applying well-defined medical criteria.”⁸¹ A futility analysis should be fully objective and based in science rather than ethics. For instance, in caring for a patient with terminal cancer, there comes a point at which chemotherapy will no longer prevent or slow the spread of the disease; after this point, it would be futile to continue with chemotherapy treatments.⁸²

There are two different types of futility: quantitative futility and qualitative futility.⁸³ Quantitatively futile treatments are those that would result in a too-slim chance of providing a “meaningful benefit.”⁸⁴ For instance, if a certain treatment option has only a one in 1,000,000 chance of working, it is likely that this would be considered to be quantitatively futile, as it does not have “a realistic chance of working.”⁸⁵ Qualitative futility draws a distinction between a treatment that has medical effect and one that has medical benefit.⁸⁶ Although a treatment may have some sort of effect on the patient, it may not be viewed as beneficial. For instance, if a patient is in a permanently unconscious state,⁸⁷ life-sustaining treatment may be viewed by doctors as being qualitatively futile because consciousness will never be regained.⁸⁸

There are some significant challenges with the notion of futility. In fact, it can be argued quite correctly that in very few cases is treatment ever truly futile.⁸⁹ As Orentlicher asserts, assessments that a treatment would be qualitatively futile is problematic “because they do not rest on objective,

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ Lawrence J Schneiderman, Nancy S Jecker & Albert R Jonsen, “Medical Futility: Its Meaning and Ethical Implications” (1990) 112 *Annals Intern Med* 949 at 951.

⁸⁴ Orentlicher, *supra* note 2 at 133.

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

⁸⁷ For more information about the debate relating to what it means to be in an unconscious or vegetative state, see: William Harvey, “Clinical Decisions Without Clinical Judgment—When a Philosophy of Medicine is Absent in the ICU” (2010) 10:3 *American Journal of Bioethics* 61; and Michael G Saunders, “Medico-Legal Aspects of Brain Death” in RN Harner & R Nacquet, eds, *Handbook of Electroencephalography and Clinic Neurophysiology* (Amsterdam: Elsevier Scientific Publishing, 1974) at ch 14.

⁸⁸ Orentlicher, *supra* note 2 at 133.

⁸⁹ *Ibid* at 139.

scientific considerations in the way that the term futile suggests.”⁹⁰ After all, the question of whether an unconscious life has value cannot “be answered by medical knowledge,”⁹¹ as “[t]here is no scientifically based way to resolve this question.”⁹²

As Orentlicher states, “For many people, life has intrinsic value, whatever its quality, and for those people, an extra day of life has important meaning. Treatment may be futile in terms of restoring consciousness, but it is not futile in terms of maintaining the patient’s life.”⁹³ Also, it is often true that preserving the life of someone in an unconscious state may bring comfort to that person’s family members and friends.⁹⁴ Who is to say that this is not beneficial? It is misleading to refer to the provision of life-sustaining treatment to a permanently unconscious patient as “medically futile.”⁹⁵

Quantitative futility is an equally troubling concept. First of all, estimations as to probability of recovery are often imprecise, inaccurate, and unreliable.⁹⁶ The recent case of Hassan Rasouli is an important reminder that physicians’ diagnoses and prognoses are not infallible.⁹⁷ Mr. Rasouli had been deemed to be in a persistent vegetative state, and, as his family disagreed with the physician’s recommendations, it seemed likely that his fate would be decided by the Supreme Court of Canada. Additional assessment, however, indicated that the initial prognosis was inaccurate, and that Mr. Rasouli was not, in fact, in a persistent vegetative state.⁹⁸ This is a direct example of the

⁹⁰ *Ibid* at 134.

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ Hilary Young, “In the Rasouli case, an opportunity to clarify patients’ rights and doctors’ power”, *The Globe and Mail* (10 September 2012) online: *The Globe and Mail* <<http://www.theglobeandmail.com/commentary/in-the-rasouli-case-an-opportunity-to-clarify-patients-rights-and-doctors-power/article4103973/>>.

⁹⁸ The Supreme Court, however, still chose to hear arguments, and a decision on the matter was rendered on 18 October 2013: *Cuthbertson v Rasouli*, 2013 SCC 53, 364 DLR (4th) 195. An earlier order requiring the decision to be made by the Consent and Capacity board (discussed below) was upheld by the majority. Chief Justice McLachlin, writing for the majority, held that the statutory scheme under the Ontario Act was the appropriate forum for determining treatment disputes, including withdrawal of life support: “An interpretation of “treatment” that is confined to what the medical caregiver considers to be of medical benefit to the patient would give these statutory purposes short shrift” at

inaccuracies that can occur in the medical world, and the unsettling reality of their potential ramifications. Secondly, there are value-judgment problems inherent in this “measure.”⁹⁹ If it is decided that there is virtually no chance that a patient could be released from hospital, treatment may be viewed as futile. Again, this approach “assumes that an extra day, week, or month of life in a hospital is not a meaningful benefit,”¹⁰⁰ which is “at odds with the views of many people.”¹⁰¹

In sum, overuse of the concept of futility is problematic because, quite often, the “real issue seems to be whether a particular life has value in a moral and philosophical sense.”¹⁰² It is important to recognize that “reasonable people disagree as to what kind of life constitutes a medical benefit, and medical knowledge cannot resolve the disagreement.”¹⁰³

It is vital to appreciate that a doctor’s duty to his patient lies at the very heart of the matter.¹⁰⁴ It is the doctor’s responsibility to care for his patient to the best of his ability; it is not up to the physician to consider how the resources being consumed by his patient might otherwise be put to use by others.¹⁰⁵ Rationing decisions are — and must remain — distinct from medical evaluations about the best form of treatment for a particular patient. Rationing should not be done under the guise of futility.¹⁰⁶

para 43. On the other hand, Abella and Karakatsanis JJ, dissenting, held at para 165 that “an extension of patient autonomy to permit a patient to insist on the continuation of treatment that is medically futile would have a detrimental impact on the standard of care and legal, ethical, and professional duties in the practice of medicine,” and seemed to place the decision regarding futility and its role back into the hands of the medical professionals.

⁹⁹ Orentlicher, *supra* note 2 at 135.

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*

¹⁰³ *Ibid.*

¹⁰⁴ Samuel Gorovitz, *Drawing the Line: Life, Death, and Ethical Choices in an American Hospital* (New York: Oxford University Press, 1991) at 120.

¹⁰⁵ *Ibid.*

¹⁰⁶ Orentlicher, *supra* note 2 at 138.

IV. REVIEW OF THE SAMUEL GOLUBCHUK CASE AND SUMMARY OF THE CPSM STATEMENT

The case of Samuel Golubchuk sparked renewed debate about many of the issues related to end-of-life treatment. Golubchuk had been a patient at Deer Lodge Care Facility for several years.¹⁰⁷ In 2003, he suffered brain damage as the result of a fall, negatively impacting his mental and physical capacities.¹⁰⁸ He underwent brain surgery in 2005 in order to remove a portion of a temporal lobe.¹⁰⁹

On October 26, 2007, at the age of 84, he was admitted to Salvation Army Grace General Hospital ("Grace Hospital") in Winnipeg, Manitoba, suffering from pneumonia and pulmonary hypertension.¹¹⁰ Although his pneumonia was eventually cured, Golubchuk's overall condition took a turn for the worse, and, on November 7, 2007, he was put into Grace Hospital's intensive care unit ("ICU") and given life-sustaining treatment (specifically, he was placed on a ventilator and given a feeding tube).¹¹¹ On November 20, 2007, the attending physician advised Golubchuk's family members that he wanted to withdraw life-sustaining treatment, as he had determined that Golubchuk was in a permanent state of unconsciousness.¹¹² Citing their Orthodox Jewish beliefs, Golubchuk's family members refused to consent to the withdrawal of life-sustaining treatment.¹¹³ On November 30, 2007, they were granted an emergency interim court injunction against the removal of life support.¹¹⁴

On January 30, 2008, in the midst of the Golubchuk matter, the CPSM released its statement regarding its position on withholding or withdrawing life-sustaining treatment.¹¹⁵ On February 13, 2008, Schulman J, of the Manitoba Court of Queen's Bench, extended an interim injunction against

¹⁰⁷ *Golubchuk v Salvation Army Grace General Hospital*, 2008 MBQB 49 at para 5, 290 DLR (4th) 46 [*Golubchuk*].

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

¹¹¹ *Ibid* at para 4.

¹¹² Fabiano Micoli, "Examining the Case of Samuel Golubchuk" (2008) 6:9 Bioethics Matters (Canadian Catholic Bioethics Institute) 1.

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ *Supra* note 10.

the removal of life-sustaining treatment until this matter could be settled at trial (which was originally scheduled for December 2008).¹¹⁶

At the beginning of June 2008, three doctors resigned from Grace Hospital's ICU, claiming that continuing to provide Golubchuk with life-sustaining treatment violated their professional and ethical responsibilities.¹¹⁷ One physician, Dr. Anand Kumar, said that the continuation of life-sustaining treatment was "tantamount to torture,"¹¹⁸ as there was no "reasonable hope of benefit."¹¹⁹ Three other physicians not normally assigned to Grace Hospital volunteered to care for Golubchuk.¹²⁰ On June 24, 2008, after over seven months on life support, Golubchuk died of "natural causes"¹²¹ at the age of 85.¹²²

Golubchuk's story was chronicled in the media, with updates appearing regularly in newspapers and on telecasts across the country and internationally.¹²³ Doctors, ethicists, theologians, legal scholars, and laypersons exchanged their views about the case. As mentioned, the CPSM statement was released at the height of this case. In it, the CPSM outlines the "minimum goal of life-sustaining treatment,"¹²⁴ which it states is:

clinically defined as the maintenance of or recovery to a level of cerebral function that enables the patient to:

- achieve awareness of self; and
- achieve awareness of environment; and
- experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment.¹²⁵

Additionally, the statement directs:

Where a physician concludes that the minimum goal is not realistically achievable and that life-sustaining treatment should be withheld or withdrawn and there is no

¹¹⁶ Golubchuk, *supra* note 107.

¹¹⁷ Micoli, *supra* note 112.

¹¹⁸ Solomon, *supra* note 1.

¹¹⁹ *Ibid.*

¹²⁰ Micoli, *supra* note 112.

¹²¹ Solomon, *supra* note 1.

¹²² Micoli, *supra* note 112 at 2.

¹²³ Solomon, *supra* note 1.

¹²⁴ *Supra* note 10 at 3.

¹²⁵ *Ibid.*

consensus with the patient/proxy/representative, the physician is not obligated to continue to try to reach a consensus before withholding or withdrawing treatment.¹²⁶

Interestingly, the statement also provides for physicians to have the authority for unilateral decision-making where the minimum goal is “realistically achievable but there are likely to be significant negative effects on the patient including, but not limited to, pain and suffering.”¹²⁷

Under the heading, “Medical, Legal and Ethical Context,”¹²⁸ the CPSM claims that “[t]he Manitoba Courts have recognized that physicians have the authority to make medical decisions to withhold or withdraw life-sustaining treatment from a patient without the consent of the patient or the patient’s family.”¹²⁹ As support for this assertion, the CPSM refers to the cases of *Re: Child and Family Services of Central Manitoba v Lavalee*¹³⁰ and *Sawatzky v Riverview Health Centre Inc.*¹³¹

Amongst lawyers and legal scholars, there is a widely held belief that “hard cases make bad law.”¹³² This phrase may be altered to fit the reality of the Golubchuk case — hard cases make bad position statements. While the CPSM should be applauded for attempting to deal with a very difficult issue, the statement on withholding or withdrawing life-sustaining treatment is flawed in two main ways.

The first major flaw of the statement has already been addressed in this paper.¹³³ The CPSM has fallen into the trap of mislabeling ethical issues as medical issues. It takes the view that the Golubchuk case is primarily medical in nature, though, in reality, this is “an ethical controversy with important medical ramifications.”¹³⁴ As Manitoba scholars Pat Murphy, George C Webster, and Brian Chaze state, “Assessments of ‘appropriate’ goals of

¹²⁶ *Ibid* at 11.

¹²⁷ Downie & McEwen, *supra* note 8 at 116.

¹²⁸ *Supra* note 10.

¹²⁹ *Ibid* at 2.

¹³⁰ *Re: Child and Family Services of Central Manitoba v Lavalee* (1997), 154 DLR (4th) 409 123 Man R (2d) 135 (Man CA).

¹³¹ *Sawatzky v Riverview Health Centre Inc* (1998), 167 DLR (4th) 359 (Man QB).

¹³² Jacob G Hornberger, “Hard Cases Make Bad Law” *The Future of Freedom Foundation* (23 March 2005), online: The Future of Freedom Foundation <<http://www.fff.org/comment/com0503k.asp>>.

¹³³ Please refer to my discussion of futility, above.

¹³⁴ Murphy, Webster & Chaze, *supra* note 3 at 71.

treatment are fundamentally ethical judgments, not clinical judgments.”¹³⁵ In their careful critique of the CPSM statement, Jocelyn Downie and Karen McEwen also argue that the minimum goals of life-sustaining treatment cannot be defined clinically.¹³⁶ They state, “The definition requires a moral and not a medical judgment and, as such, does not rest with physicians but rather with patients, their surrogate decision-makers (if they are incompetent), and society.”¹³⁷ Since doctors are not the only stakeholders here, they should not be able to make a unilateral decision to withdraw life-sustaining treatment.¹³⁸

There are other important considerations that flow from the mislabeling of ethical issues as medical issues. Joel B Zivot, one of the physicians who volunteered to treat Golubchuk after others refused, draws “a distinction between ‘won’t’ and ‘can’t,’ with the former being value laden, the latter set by the limits of conventional critical care medical practice,”¹³⁹ which is a distinction often missed by healthcare professionals.¹⁴⁰ Because of the role that value judgments play in decisions relating to the withdrawal of life-sustaining treatment, decisions vary greatly from physician to physician.¹⁴¹ Especially in a public healthcare system, this means that luck of the draw with respect to physician assignment can determine whether treatment is continued or withdrawn.¹⁴²

By claiming that the identified minimum goal is “clinically defined,”¹⁴³ the CPSM statement “dresses up an ethical judgment as a medical decision.”¹⁴⁴ In the process, it “leaves patients subject to the personal or idiosyncratic views of physicians.”¹⁴⁵ Although doctors should never be forced

¹³⁵ *Ibid* at 72.

¹³⁶ Downie & McEwen, *supra* note 8 at 115.

¹³⁷ *Ibid.*

¹³⁸ Zivot, *supra* note 12.

¹³⁹ *Ibid.*

¹⁴⁰ See e.g. Robert M Veatch & Carol Mason Spicer, “Medically Futile Care: The Role of the Physician in Setting Limits” (1992) XVIII (1 & 2) *Am J L & Med* 15; Susan B Rubin, “If We Think It’s Futile, Can’t We Just Say No?” (2007) 19:1 *HEC Forum* 45; and Wesley J Smith, “Futile-Care Theory: Assisted Suicide’s First Cousin” (Summer 2008) 34:3 *Human Life Review* 41.

¹⁴¹ Zivot, *supra* note 12.

¹⁴² *Ibid.*

¹⁴³ *Supra* note 10 at 3.

¹⁴⁴ Murphy, Webster & Chaze, *supra* note 3 at 72.

¹⁴⁵ *Ibid.*

to take actions that they believe violate their professional and ethical obligations, this should mean that they have the freedom to walk away from a case (pending the assignment of a willing replacement physician); it should not mean that doctors have the ability to make unilateral decisions concerning treatment withdrawal.

In sum, as Murphy, Webster, and Chaze conclude, “[w]hile physicians may properly assess the anticipated effectiveness of interventions, their medical expertise, per se, does not qualify them to assess the worthwhileness, or value, of interventions.”¹⁴⁶ Decisions relating to withdrawal of treatment are inherently value-laden, and value assessments almost always includes some consideration—conscious or subconscious—of the costs involved.¹⁴⁷ Although it is a very normal question to ask as a typical citizen, physicians must guard against asking whether a certain course of treatment is “worth it.”¹⁴⁸ At the very least, doctors should not be given the power to unilaterally make what may amount—quite literally—to a life-terminating decision when that decision is based on values. Their medical knowledge and training does not necessarily mean that their values are worth more than those of anyone else.

The second major flaw with the CPSM statement is the misguided belief that the courts have recognized that doctors “have the authority to make medical decisions to withhold or withdraw life-sustaining treatment from a patient without the consent of the patient or the patient’s family.”¹⁴⁹ The CPSM’s conclusion is based on a misinterpretation of relevant case law.¹⁵⁰ As Downie and McEwen state, the CPSM’s portrayal of the status of the law “is not accurate.”¹⁵¹ While “[i]t is arguably correct to say that, in Manitoba, physicians have the legal authority to unilaterally withhold resuscitation for a patient in a persistent vegetative state,”¹⁵² it cannot be correctly stated that the law “is settled beyond the application of Do Not Resuscitate (DNR) orders for patients in a persistent vegetative state.”¹⁵³ In fact, as Schulman J quite

¹⁴⁶ *Ibid.*

¹⁴⁷ Orentlicher, *supra* note 2 at 138.

¹⁴⁸ *Ibid.*

¹⁴⁹ *Supra* note 10 at 2.

¹⁵⁰ Downie & McEwen, *supra* note 8.

¹⁵¹ *Ibid* at 117.

¹⁵² *Ibid.*

¹⁵³ For the purposes of this discussion, it is sufficient to state that the law is unsettled on the question of a doctor’s ability to make unilateral withdrawal-of-treatment decisions. Please note that the series of DNR cases referenced by the CPSM can be distinguished from the

correctly states in his ruling extending the interim injunction in *Golubchuk v Salvation Army Grace General Hospital*, “Contrary to the assertion of the defendants, it is not settled law that, in the event of disagreement between a physician and his patient as to withdrawal of life supports, the physician has the final say.”¹⁵⁴

V. THE ROLE OF THE MANITOBA LAW REFORM COMMISSION

It is interesting to note that the CPSM statement is based in large part on a 2003 report from the Manitoba Law Reform Commission (“the MLRC”).¹⁵⁵ Unfortunately, the CPSM did not wholly follow the recommendations of the MLRC. The final product – the CPSM statement – falls short, in part because its delivery was rushed in order to deal with the *Golubchuk* case.¹⁵⁶

The MLRC report includes a number of noteworthy comments. Firstly, it states that “[t]he case law...is not authoritative and it is not uniform but it is fair to conclude as a general proposition that the physician has the ultimate power to withhold or withdraw life sustaining treatment without the consent of the patient.”¹⁵⁷ While the first part of the sentence is quite accurate, it is difficult to see how the conclusion that physicians have the final say with regard to the withdrawal of life-sustaining treatment is reached. This is especially true in light of an explanatory statement in the same paragraph of the report, which reads, “This may appear to be reflective of the discredited authoritarian, paternalistic practices of the past but there is reason for caution before entertaining a right to life sustaining medical treatment.”¹⁵⁸ In general, the MLRC report places greater emphasis on the rejection of the notion of an unrestricted right to life-sustaining treatment than on the idea that doctors should have the ability to make unilateral decisions respecting end-of-life treatments.¹⁵⁹ Given the issues related to medical-resource scarcity, it is

issues related to the withdrawal of life-sustaining treatment in cases such as the one involving *Golubchuk*. A thorough review of the case law in this area is outside the scope of this paper. For a very detailed analysis of the case law, please see Downie & McEwen, *supra* note 8 at 116-119.

¹⁵⁴ *Golubchuk*, *supra* note 107 at para 25.

¹⁵⁵ *Supra* note 65.

¹⁵⁶ Murphy, Webster & Chaze, *supra* note 3.

¹⁵⁷ *Supra* note 65 at 4.

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid.*

difficult to disagree with the MLRC's position that there should not be an unfettered legal right to life-sustaining treatment.¹⁶⁰ However, it is much easier to take issue with the suggestion that doctors should have the final decision-making authority in treatment-withdrawal situations. Those responsible for drafting the CPSM statement disregard a great deal of the MLRC report; it is as if the CPSM statement is based on a truncated summary of the MLRC document.

Unlike the CPSM, the MLRC recognizes that "[t]he selection of goals requires a value judgment."¹⁶¹ It is also significant that the MLRC recommends that "[t]he notion of futility should not be used"¹⁶² in deciding whether a treatment would be "medically inappropriate or professionally unethical."¹⁶³ In part, it is said that the concept of futility should be avoided because "it risks undue emphasis being placed on an evaluation of the life at issue,"¹⁶⁴ which refers to the value issues previously discussed in this paper.¹⁶⁵ Unfortunately, the MLRC's further explanation on this particular topic is rather perplexing:

Such subjective views may not be entirely extinguishable from the determination of whether treatment should be withheld or withdrawn, but to the extent possible the decision should be ultimately justifiable on the basis of a physician's professional and ethical obligations and clinical judgment...¹⁶⁶

This statement causes even greater confusion when read in conjunction with the conclusion that "human and economic health care resources are strained and some professional control over the use of medical technology to sustain life indefinitely is appropriate."¹⁶⁷ This would seem to imply that doctors should play an active role in the rationing of medical resources, which necessarily would mean that physicians would act as arbiters of individual and societal values.

¹⁶⁰ *Ibid* at 13.

¹⁶¹ *Ibid* at 66.

¹⁶² *Ibid* at 12.

¹⁶³ *Ibid*.

¹⁶⁴ *Ibid*.

¹⁶⁵ Please refer to my discussion of futility, and my discussion of the flaws of the CPSM statement, above.

¹⁶⁶ *Supra* note 65 at 12-13.

¹⁶⁷ *Ibid* at 13.

Finally, though the MLRC would like “informal dispute resolution procedures”¹⁶⁸ to be followed where physicians and a patient’s family members are at an impasse, the MLRC “[does] not favour the establishment of internal or external committees, boards or arbitrators”¹⁶⁹ to make decisions relating to the potential withdrawal of life-sustaining treatment. The MLRC argues that “such cases will be infrequent and the delay, cost and formality involved in administrative tribunals is unattractive.”¹⁷⁰ Logistical concerns — particularly those related to cost and geography—are cited.¹⁷¹ Furthermore, it is suggested that “[t]here is also the unsettling prospect of creating a disincentive to resolve these issues informally with good faith and goodwill.”¹⁷² However, this stance overlooks the many advantages of administrative tribunals, including the fact that they are created in large part to create an efficient mechanism for settling disputes outside of the formal and traditional court system.¹⁷³ Although still relatively rare, these cases are appearing in courts with increasing frequency. It has been suggested that this trend will continue, in the absence of clear guidance from the Supreme Court of Canada,¹⁷⁴ but, as the *Rasouli* decision is pending, at the time of writing, perhaps a greater degree of direction will be available soon.

VI. PROPOSAL FOR A BETTER APPROACH TO DECISION-MAKING

The current approach — enunciated by the CPSM statement — confuses ethical and medical issues.¹⁷⁵ Doctors are responsible for providing an assessment of the patient’s condition and also for giving a recommendation as to what should be done next, weighing a number of different factors. This quite often involves value considerations, and may include a cost-benefit analysis with respect to resource rationing.¹⁷⁶ Attending physicians are given final decision-making power; they are told that they may unilaterally withdraw

¹⁶⁸ *Ibid* at 107.

¹⁶⁹ *Ibid* at 13.

¹⁷⁰ *Ibid.*

¹⁷¹ *Ibid.*

¹⁷² *Ibid.*

¹⁷³ *Dunsmuir v New Brunswick*, 2008 SCC 9 at para 30, [2008] 1 SCR 190.

¹⁷⁴ Solomon, *supra* note 1.

¹⁷⁵ Downie & McEwen, *supra* note 8 at 119.

¹⁷⁶ *Ibid.*

life-sustaining treatment in situations where family members refuse to consent to this recommended course of action. In essence, this may be referred to as the “Judge Dredd” approach to medicine; doctors are asked to play the medical equivalents to the roles of judge, jury, and executioner.¹⁷⁷ Although the CPSM statement calls for the attending physician to consult with another doctor where possible,¹⁷⁸ in some cases, doctors are hesitant to disagree with the assessments and recommendations of their colleagues.¹⁷⁹

It would be preferable to have a structured system in place to deal with the contentious cases where family members disagree with the doctor’s recommendation to withdraw life-sustaining treatment. Rather than leaving the final decision with physicians, a mechanism should be established, through which many different factors could be assessed.¹⁸⁰ After all, the MLRC report acknowledges a lack of community consensus with respect to the doctor’s power to unilaterally withdraw life-sustaining treatment.¹⁸¹

It must be acknowledged openly that rationing plays a role in the determination of whether life-sustaining treatment should continue to be offered.¹⁸² This issue must not be evaded; once it is discussed in a free and open manner, clear guidelines can be established to guide decision-making. Because of the opportunity for a relatively objective analysis, and for input from a variety of actors, this is inherently better than a system that leaves rationing decisions in the hands of one person, who will inevitably have his own biases, beliefs, morals, ethics, and values.¹⁸³

Israeli scholars Alan Jotkowitz, Shimon Glick, and Ari Z Zivotofsky state:

It may...be incumbent upon societies with limited resources—and all societies are to some extent limited in what they can offer—to set societal priorities on what medical resources are to be provided at societal expense. But these are societal and not medical responsibilities. The physicians have the expertise and knowledge, which they provide to society’s decision makers, but it is not they who may arbitrarily impose their values on their patients... [T]hese decisions should not be solely in the

¹⁷⁷ “Judge, jury & executioner” *The Firm* (14 January 2008), online: The Firm <http://www.firmmagazine.com/features/354/Judge,_jury_%26_Executioner.html>.

¹⁷⁸ *Supra* note 10 at 11.

¹⁷⁹ June Isaacson Kailes, “Managing Your Own Health Care” *Blindness Support Services*, online: Blindness Support Services <<http://www.vitalco.net/BlindnessSupport/ManagingCare.htm>>.

¹⁸⁰ Murphy, Webster & Chaze, *supra* note 3.

¹⁸¹ *Supra* note 65 at 5.

¹⁸² Orentlicher, *supra* note 2 at 139. Please also see Hurst et al, *supra* note 77.

¹⁸³ Murphy, Webster & Chaze, *supra* note 3.

hands of physicians... Until a society undergoes [a process of determining rationing protocols and procedures], it is not the role of a physician to play God, legislator, or judge.¹⁸⁴

Zivot argues that it is inappropriate to ask physicians to make bedside social-justice decisions such as those related to rationing.¹⁸⁵ Orentlicher outlines four main problems with physician-directed rationing decisions.¹⁸⁶ Firstly, he states that it would be impossible for an individual physician to acquire and consider all necessary information—including information relating to costs and benefits — in reaching a fair and just decision.¹⁸⁷ Secondly, there would be a great deal of variation between doctors, as “[s]ome physicians will err in favor of conserving society’s limited resources,”¹⁸⁸ while “others will err in favor of treating the patient before them.”¹⁸⁹ Thirdly, it is inappropriate to give physicians responsibility for rationing decisions, as they have no unique expertise in this area.¹⁹⁰ Finally, where physicians act as rationers, this creates “a serious conflict of interest between the needs of their own patients and the needs of other patients.”¹⁹¹ This is because “[r]ationing inevitably requires physicians to balance the interests of patients before them with the interests of patients who may come to them next month or that may come to other doctors.”¹⁹²

In light of these many problems, it would be best to establish an administrative tribunal consisting of a wide variety of experts, capable of weighing a number of different considerations. The most effective proposal would require a panel comprised of at least one doctor, one lawyer, one ethicist, one social worker, and one economist, in order to ensure that a number of different perspectives are represented.¹⁹³ An approach similar to this has been utilized in other jurisdictions, and it seems to have successfully addressed the concerns arising from unilateral decision making, by ensuring

¹⁸⁴ Jotkowicz, Glick & Zivotofsky, *supra* note 18.

¹⁸⁵ Zivot, *supra* note 12 at 57.

¹⁸⁶ Orentlicher, *supra* note 2 at 143-144.

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid* at 144.

¹⁸⁹ *Ibid.*

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.*

¹⁹² *Ibid.*

¹⁹³ Berger, *supra* note 33 at 60.

an objective, holistic assessment in determining the 'best interests' of the patient in each particular case.

A. Ontario's Consent and Capacity Board

In Ontario, the tribunal approach has already been adopted as a means of dealing with disputed end of life decisions. The *Health Care Consent Act*¹⁹⁴ provides factors that a substitute decision maker (SDM) must consider when giving or refusing consent to treatment for a patient that no longer has the capacity to decide for him or herself. It stipulates that the SDM must decide in accordance with the patient's wishes, if they are known, or, if the wishes are not known, the decision must be in the patient's best interests.¹⁹⁵

The Consent and Capacity Board is an independent body, created under the *Health Care Consent Act*, and it operates as a "neutral third party that adjudicates on matters relating to consent to treatment and capacity to make treatment decisions".¹⁹⁶ The Board is comprised of lawyers, psychiatrists, and members of the general public, appointed by the Lieutenant-Governor in Council.¹⁹⁷ Among other tasks, one role of the Board is to hear disputes, between the substitute decision maker (SDM) and the medical staff, relating to whether or not a proposed treatment plan is in the 'best interests' of the specific patient.¹⁹⁸ The 'best interests' test involves an assessment of both patient's considerations, such as the patient's values and beliefs, as well as medical considerations.¹⁹⁹

Studies indicate that issues arise as a result of a discrepancy in terms of the interpretation of 'best interests'.²⁰⁰ SDMs tend to incorporate, and focus heavily on, religious or faith-based considerations, and personal values held by

¹⁹⁴ *Health Care Consent Act*, SO 1996, c 2.

¹⁹⁵ *Ibid* at s 21(1).

¹⁹⁶ Robert W Sibbald and Paula Chidwick, "Best Interests at End of Life: A Review of Decisions Made by the Consent and Capacity Board of Ontario" (2010) 25 *Journal of Critical Care* 171.e1 at 171.e2.

¹⁹⁷ Information regarding the structure of the Consent and Capacity Board is available online: The Ontario Consent and Capacity Board <<http://www.ccboard.on.ca>>.

¹⁹⁸ *Supra* note 196.

¹⁹⁹ Paula Chidwick, Robert Sibbald & Laura Hawryluck, "Best Interests at End of Life: An Updated Review of Decisions Made by the Consent and Capacity Board of Ontario" (2013) 28 *Journal of Critical Care* 22 at 26.

²⁰⁰ *Supra* note 196 at 171.e4-171.e5.

the patient.²⁰¹ Evidence also suggests that SDMs demonstrate a habit of putting forth “their own values and not those of the patient when arguing for the best interests of the patient”.²⁰² In contrast, physicians have a greater tendency to interpret ‘best interests’ strictly in terms of clinical conditions.²⁰³

When a conflict such as this arises, the physician or the medical team may make an application to the Board, if they believe that the SDM’s refusal to consent is not in the best interests of the patient.²⁰⁴ Alternatively, an application can be made by an SDM, if dispute between SDMs prevents a decision from taking place.²⁰⁵ The Board then determines whether or not the SDM is properly weighing the considerations required by the legislation, and makes an order according to the “legally interpreted best interests of the patient”.²⁰⁶

Simply put, the Board is in a better position than either party to objectively assess a patient’s situation, and align their treatment plan with the stated purposes of the *Health Care Consent Act*. The legislation provides the requirements that must be considered in deciding whether to grant or refuse consent, and the Board is in place to ensure that both the SDM and the treating physician are abiding by those considerations. If the Board finds that the SDM is not in compliance, the SDM can be directed to consent to treatment, and the Board’s order is legally binding, and can only be altered by an appeal through the courts.²⁰⁷ This approach has been lauded as “uncomplicated and expeditious”,²⁰⁸ and it removes the burden of resource rationing decisions from the physician. Unilateral decision making is eliminated, SDMs or family members have the opportunity to have their concerns heard, and controversial cases are processed through an

²⁰¹ *Ibid* at 171.e4. Sibbald and Chidwick point out that there is a distinct difference between values held by a patient, and the wishes, express or implied, of a patient. Something that is considered a statement of value, as expressed by the patient, is therefore not sufficient to constitute a prior expressed wish; *ibid* at 171.e5.

²⁰² *Ibid* at 171.e4.

²⁰³ *Ibid*.

²⁰⁴ *Supra* note 199 at 23.

²⁰⁵ *Supra* note 196 at 171.e2.

²⁰⁶ *Supra* note 199 at 23.

²⁰⁷ Thaddeus Mason Pope, “Surrogate Selection: An Increasingly Viable, But Limited, Solution to Intractable Futility Disputes” (2010) 3:2 St Louis U J Health L & Pol’y 183 at 241.

²⁰⁸ *Ibid*.

independent Board tasked with ensuring that all decisions are made in conformity with the law.

In recent years, there has been a drastic increase in cases of end of life disputes brought before the Consent and Capacity Board.²⁰⁹ As discussed above, this will perhaps be tempered by the arrival of the Supreme Court's decision in *Rasouli*. Nevertheless, the Ontario Board has been busy, and its experience is useful in terms of better articulating the causes of dispute between parties, as well as highlighting the strategies the Board has utilized to resolve these conflicts, and illustrating the effectiveness of an independent tribunal when it comes to the sensitive matter of end of life decisions.

B. Manitoba Tribunal – A Proposal

It is vital to have some sort of mechanism in place for resolving disputes related to life-sustaining treatment. It is unrealistic to expect that family members and doctors will always be able to reach a consensus through the completely informal manner preferred by the MLRC.²¹⁰ However, it is also quite clear that courts are not well suited to making the speedy – and cost-effective – decisions necessary in cases such as these.²¹¹

This tribunal would make decisions on the basis of a combination of the principles discussed in the allocation section of this paper.²¹² Clear guidelines for decision-making would have to be developed through a process involving public consultation.²¹³ Although establishing the exact framework of this body is beyond the scope of this paper, it is likely that such an administrative tribunal would draw on the Ontario experience, and also employ some variation of the “Accountability for Reasonableness” model developed by Norman Daniels and James E Sabin.²¹⁴ This model emphasizes four conditions that “are necessary if a decision-making process about health care limits is to address the legitimacy problem”²¹⁵ regarding rationing decisions.

²⁰⁹ *Supra* note 199 at 22-23.

²¹⁰ “Winnipeg hospitals draft end-of-life guideline” *CBC News* (25 March 2011), online: CBC News <<http://www.cbc.ca/news/health/story/2011/03/25/mb-end-of-life-guideline-winnipeg.html>>.

²¹¹ Berger, *supra* note 33 at 61.

²¹² Please refer to my discussion of allocation systems, above.

²¹³ Jotkowitz, Glick & Zivotofsky, *supra* note 18.

²¹⁴ Norman Daniels & James E Sabin, *Setting Limits Fairly: Can we learn to share medical resources?* (New York: Oxford University Press, 2002).

²¹⁵ *Ibid* at 11.

Firstly, the transparency condition requires that decisions regarding limit-setting and rationing must be public, and the reasons for these decisions must be made public.²¹⁶ Secondly, the relevancy condition dictates that “the grounds for decisions must be ones that fair-minded people can agree are relevant to meeting health care needs fairly under reasonable resource constraints.”²¹⁷ Thirdly, rationing decisions “must be subject to revision and appeal, and the process for doing that must itself meet the first two conditions.”²¹⁸ Finally, effective regulation must be in place to ensure that all conditions are met.²¹⁹

As the MLRC report correctly states, the primary concern of physicians “is the well-being of their patients.”²²⁰ Four ethical principles, originally put forth by prominent scholars Tom L Beauchamp and James F Childress, guide doctors’ pursuit of this objective. This “Georgetown Mantra”, as it has come to be known, outlines the four universal principles of biomedical ethics:²²¹

- Beneficence – the desire for a good outcome and the restoration of health;
- Non-maleficence – the avoidance of further harm to the patient;
- Autonomy – embodies respect for the patient and his or her wishes;
- Justice – involves reasonableness and equity in decision making.²²²

²¹⁶ *Ibid* at 11-12.

²¹⁷ *Ibid* at 12.

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*

²²⁰ *Supra* note 65 at 6.

²²¹ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics*, 5th ed (Oxford: Oxford University Press, 2001). The MLRC report highlighted this approach and used these principles to support the conclusions drawn. However, these principles, despite forming the basis of much literature in this area, have been widely criticized, and are generally understood to be helpful but not comprehensive. See e.g. Tuija Takala, “What is Wrong with Global Bioethics? On the Limitations of the Four Principles Approach” (2001) 10:1 *Cambridge Quarterly of Healthcare Ethics* 72; Matti Häyry, “European Values in Bioethics: Why, What, and How to be Used?” (2003) 24:3 *Theoretical Medicine and Bioethics* 199.

²²² *Supra* note 65 at 6.

A tribunal should keep these principles at the forefront, when attempting to resolve end of life decision conflicts. Additionally, because of the high level of expertise of the proposed administrative body, its rulings should be protected from judicial review inasmuch as is possible through the use of a strong privative clause.²²³ After all, the goal is to prevent protracted litigation in these cases, which are usually very time-sensitive.²²⁴

Though it is impossible at this stage to envision the exact form that this tribunal would take, it is important to acknowledge that families who have gone through these difficult situations are very supportive of the tribunal approach. In fact, Golubchuk's daughter, Miriam Geller, has called on the Government of Manitoba to establish a panel that has the power to adjudicate these types of disputes.²²⁵ Interestingly, Dr. Kumar – the physician once so vehemently opposed to the stance taken by Geller and other members of Golubchuk's family that he resigned from his post—agrees with Geller's demand for the creation of an administrative body to deal with these contentious cases.²²⁶

Although this tribunal must be given the power to decide that life-sustaining treatment be withdrawn in cases where this is deemed by its members to be appropriate, very strict controls and standards must exist in order to protect against abuses and government cost cutting. Additionally, where the board rules that a patient should be removed from life support, family members generally should be given the option of continuing to pay for life-sustaining treatment if they so desire.²²⁷ Of course, this brings with it some of the same concerns raised with respect to the private healthcare model in the US, though not to the same extent. This may lead to the emergence of a new insurance market – either private or public – offering to cover additional treatment above and beyond what the government is prepared to pay for in these rare cases. Of course, the proposed approach would not deal with situation-specific scarcity issues; rather, it would be a cost-recovery method intended to deal with long-term, systemic scarcity problems. This

²²³ Dunsmuir, *supra* note 173 at para 27.

²²⁴ Berger, *supra* note 33 at 61.

²²⁵ *Supra* note 9.

²²⁶ *Ibid.*

²²⁷ In its current form, the *Canada Health Act*, RSC 1985, c C-6, would be unlikely to accommodate such a proposal; as a result, it is suggested that the Act be amended to allow such an approach to take place.

option could not be made available unless the resources could be spared or redirected in that particular situation (at that time and place), without putting another patient's life in serious jeopardy. Also, there must be safeguards in place to protect against perverse incentive structures that would encourage doctors – through the emergence of a secondary (and likely private) market – to shift their practice to these sorts of cases while refusing other, less-lucrative cases.²²⁸

VII. CONCLUSION

Members of the public are generally uncomfortable with the idea of tribunals deciding whether life-sustaining treatment should be continued or withdrawn.²²⁹ They would prefer to think that all decisions are medically based, meaning that nature has run its course, and that doctors have done everything in their power to extend life. This view is naïve; after all, it is true that “medicine is not an exact science.”²³⁰ Furthermore, it must be recognized that many decisions that are enveloped in objective and scientific language are in fact quite subjective in nature.²³¹

Healthcare spending accounts for nearly half of each province's budget.²³² Approximately 25 percent of all healthcare costs are “devoted to caring for patients in their last year of life.”²³³ This is an astoundingly high number, and it is sure to grow, as healthcare inflation far exceeds annual inflation rates.²³⁴ It is time for society to acknowledge this reality and take steps to address issues relating to end-of-life care in a transparent and principled manner. Individual physicians should not have the power to make unilateral rationing

²²⁸ Zivot, *supra* note 12 at 57.

²²⁹ “Poll: Most physicians support care once mischaracterized as ‘death panels’” *The Daily Briefing* (17 November 2011), online: The Advisory Board Company <<http://www.advisory.com/Daily-Briefing/2011/11/17/Expanding-end-of-life-care/>>.

²³⁰ *Supra* note 65 at 65.

²³¹ Orentlicher, *supra* note 2 at 139.

²³² Lisa Priest, “How much does dying cost Canadians?” *The Globe and Mail* (28 November 2011), online *The Globe and Mail* <<http://www.theglobeandmail.com/life/health/end-of-life/how-much-does-dying-cost-canadians/article2252845/>>.

²³³ *Ibid.*

²³⁴ Kevin Press, “The truth about healthcare inflation” *Sun Life Financial Blog* (30 August 2010), online *Sun Life Assurance* <<http://blogs.sunlife.ca/todayseconomy/2010/08/the-truth-about-healthcare-inflation/>>.

decisions on behalf of society, especially where these decisions are made as a result of ethical judgments being mislabeled as medical determinations.

